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| **Summary of Mental Health and Substance Abuse Benefits for Auburn University**  **Effective January 1, 2021**  **Summary Document #: 559777215383** | | |
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| **IMPORTANT INFORMATION:** All benefits are based on the appropriate level of care and medical necessity guidelines. Provider/facility licensure by the state to provide covered services and facility accreditation by The Joint Commission or CARF is required. | | |
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| **Calendar Year** **Deductible** | **$500** Per Person Per Year with a **Three (3)** Member Family Maximum | |
| **Calendar Year Out-of-Pocket** **Maximum** | **$8,550** Individual / **$17,100** Aggregate Family Maximum | |
| 1. Your calendar year deductible counts toward your out-of-pocket maximum 2. The family calendar year deductible and out-of-pocket maximum is embedded, meaning that each member has his or her own deductible/out-of-pocket maximum in addition to the shared family deductible/out-of-pocket maximum. Any amount paid toward an individual’s deductible/out-of-pocket maximum also applies toward the family’s deductible/out-of-pocket maximum. This allows individuals in the family to have their costs covered before the family deductible/out-of-pocket maximum has been met. Once the family deductible/out-of-pocket maximum is met, the plan covers charges for any family member. 3. **Deductible Carryover:** When covered charges are applied towards the calendar year deductible for services rendered in October, November, or December, those covered charges will be credited towards the calendar year deductible for the following year. | | |
| **MENTAL HEALTH PROGRAM** | | |
| 1. ***INPATIENT SERVICES*** | | |
| **Benefits** | **In-Network** | **Out-of-Network** |
| * Acute Inpatient Hospitalization * Inpatient Electroconvulsive Therapy (ECT) * Partial Hospitalization/Day Treatment (PHP) * Intensive Outpatient Program (IOP)   **Residential Services Are NOT COVERED** | **Pre-admission Certification Required**  **Call 800-677-4544**  **LIMITATIONS:** Inpatient Services Limited to **30 Days Total Per Calendar Year Combined** In- Network and Out-of-Network  Covered At **100%** Of Allowed Amount After Copay, Subject to Calendar Year Deductible  **Patient Responsibility: $300** Copay Per Admission Subject to Calendar Year Deductible  **PHP: Two (2)** PHP Days Equal **One (1)** Inpatient Day  **IOP: Two (2)** IOP Days Equal **One (1)** Inpatient Day | **Pre-admission Certification Required**  **Call 800-677-4544**  **LIMITATIONS:** Inpatient Services Limited to **30 Days Total Per Calendar Year Combined** In- Network and Out-of-Network  Covered At **80%** Of Allowed Amount Subject to Calendar Year Deductible  **Patient Responsibility:** All Billed Charges Not Covered by The *Plan*  **PHP: Two (2)** PHP Days Equal **One (1)** Inpatient Day  **IOP: Two (2)** IOP Days Equal **One (1)** Inpatient Day |
| 1. ***OUTPATIENT OFFICE VISITS*** | | |
| **Description** | **In-Network** | **Out-of-Network** |
| Outpatient Office Visits | **LIMITATIONS:** Outpatient Office Visits Limited to **30 Visits/Sessions/Group Therapy Sessions (**or any combination thereof) Total **Each Calendar Year Combined** In-Network and Out-of-Network**, Combined** Mental Health, Substance Abuse, and Eating Disorder Programs  Covered At **100%** Of Allowed Amount After Copay  **Patient Responsibility: $30** Copay Per Visit/ Session/Group Therapy Session | **LIMITATIONS:** Outpatient Office Visits Limited to **30 Visits/Sessions/Group Therapy Sessions (**or any combination thereof) Total **Each Calendar Year Combined** In-Network and Out-of-Network**, Combined** Mental Health, Substance Abuse, and Eating Disorder Programs  Covered At **80%** Of Allowed Amount  **Patient Responsibility:** All Billed Charges Not Covered by The *Plan* |
| 1. ***PSYCHOLOGICAL/NEUROPSYCHOLOGICAL TESTING*** | | |
| **Description** | **In-Network** | **Out-of-Network** |
| Psychological/Neuropsychological Testing | **Precertification Required**  **Call 800-677-4544**  **LIMITATIONS: Limited to Five (5) Hours Per Member Per Calendar Year Combined In- Network and Out-of-Network**  Covered At **100%** Of Allowed Amount After Copay  **Patient Responsibility: $30** Copay Per Visit/Session/Group Therapy Session | **Precertification Required**  **Call 800-677-4544**  **LIMITATIONS: Limited to Five (5) Hours Per Member Per Calendar Year Combined In- Network and Out-of-Network**  Covered At **80%** Of Allowed Amount  **Patient Responsibility:** All Billed Charges Not Covered by The *Plan* |

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| **SUBSTANCE ABUSE PROGRAM—ONCE PER LIFETIME PER INSURED MEMBER** | | |
| 1. ***INPATIENT SERVICES*** | | |
| **Benefits** | **In-Network** | **Out-of-Network** |
| * Detoxification * Partial Hospitalization/Day Treatment (PHP) * Intensive Outpatient Program (IOP)   Residential Services Are **NOT COVERED** | **Pre-admission Certification Required**  **Call 800-677-4544**  **LIMITATIONS:** Inpatient Services Limited to **30 Days Total Per Lifetime** Per Insured Member  Covered At **100%** Of Allowed Amount After Copay, Subject to Calendar Year Deductible  **Patient Responsibility: $300** Copay Per Admission Subject to Calendar Year Deductible  **PHP: Two (2)** PHP Days Equal **One (1)** Inpatient Day  **IOP: Two (2)** IOP Days Equal **One (1)** Inpatient Day | **NO OUT-OF NETWORK BENEFIT** |
| 1. ***OUTPATIENT OFFICE VISITS*** | | |
| Ambulatory Detoxification (Office Visit) | **LIMITATIONS:** Outpatient Office Visits Limited to **30 Visits/Sessions/Group Therapy Sessions (**or any combination thereof) Total **Each Calendar Year, Combined** Mental Health, Substance Abuse, and Eating Disorder Programs  Covered At **100%** Of Allowed Amount After Copay  **Patient Responsibility: $30** Copay Per Visit/Session/Group Therapy Session | **NO OUT-OF NETWORK BENEFIT** |
| **EATING DISORDERS PROGRAM—ONCE PER LIFETIME PER INSURED MEMBER** | | |
| 1. ***INPATIENT SERVICES*** | | |
| **Benefits** | **In-Network** | **Out-of-Network** |
| * Inpatient Hospitalization * Partial Hospitalization/Day Treatment (PHP) * Intensive Outpatient Program (IOP)   Residential Services Are **NOT COVERED** | **Pre-admission Certification Required**  **Call 800-677-4544**  **LIMITATIONS:** Inpatient Services Limited to **30 Days Total Per Lifetime** Per Insured Member  Covered At **100%** Of Allowed Amount After Copay, Subject to Calendar Year Deductible  **Patient Responsibility: $300** Copay Per Admission Subject to Calendar Year Deductible  **PHP: Two (2)** PHP Days Equal **One (1)** Inpatient Day  **IOP: Two (2)** IOP Days Equal **One (1)** Inpatient Day | **NO OUT-OF NETWORK BENEFIT** |
| 1. ***OUTPATIENT OFFICE VISITS*** | | |
| Outpatient Office Visits | **LIMITATIONS:** Outpatient Office Visits Limited to **30 Visits/Sessions/Group Therapy Sessions (**or any combination thereof) Total **Each Calendar Year, Combined** Mental Health, Substance Abuse, and Eating Disorder Programs  Covered At **100%** Of Allowed Amount After Copay  **Patient Responsibility: $30** Copay Per Visit/Session/Group Therapy Session | **NO OUT-OF NETWORK BENEFIT** |

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| **APPLIED BEHAVIOR ANALYSIS (ABA) FOR THE TREATMENT OF AUTISM SPECTRUM DISORDERS** | | | |
| **Benefits** | | **In-Network** | **Out-of-Network** |
| Applied Behavior Analysis (ABA) for the Treatment of Autism Spectrum Disorders  **Based on Eligibility and Clinical Criteria Being Met** | **Pre-certification Required**  **Call 800-677-4544**  **Ages 0-9:** Up to **$20,000** per child per calendar year  **Ages 10-13:** Up to **$15,000** per child per calendar year  **Ages 14-18:** Up to **$10,000** per child per calendar year | **NO OUT-OF NETWORK BENEFIT** |
| **PROFESSIONAL SERVICES** | | | |
| **Benefits** | | **In-Network** | **Out-of-Network** |
| Inpatient Physician Services in Conjunction with Approved Inpatient Services | | Covered At **100%** Of Allowed Amount  **Patient Responsibility: None** | Covered At **80%** Of Allowed Amount  **Patient Responsibility:** All Billed Charges Not Covered by The *Plan* |
| Anesthesia in Conjunction with Approved ECT Treatment | | Covered At **100%** Of Allowed Amount Subject to the Inpatient Copay Amount  **Patient Responsibility: None** | Covered At **80%** Of Allowed Amount  **Patient Responsibility:** All Billed Charges Not Covered by The *Plan* |
| **COVERED BY MEDICAL PLAN** | | | |
| * Ambulance * Emergency Department * Imaging * Lab Work | | **COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL** | **COVERED BY THE AUBURN UNIVERSITY MEDICAL PLAN THROUGH BCBSAL** |
| **BEHAVIORAL HEALTH CARE MANAGEMENT** | | | |
| Care management is a service offered by *the Plan* to assist you with difficult behavioral health care needs. You have a personal care manager who acts as your advocate, assisting you whenever you have questions or concerns. Call American Behavioral at 800-677-4544 to talk to your personal care manager. | | | |